

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6963

CERTIFICATE OF DEATH

06935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. LENGTH OF STAY IN TB <i>39 yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		d. STREET ADDRESS <i>811 Giles</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William J. Ansalovich</i>		4. DATE OF DEATH Month <i>6</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/9/1883</i>
9. AGE (In years, last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Engineer Penn. R.R.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Emanuel Ansalovich</i>		14. MOTHER'S MAIDEN NAME <i>Mary Loft</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Francis Ansalovich</i>		Address <i>811 Giles St. Harford</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decongestion</i> <i>42010</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio sclerotic heart disease</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Feb to June</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>—</i> a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>60</i> , to <i>June 11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>June 11</i> , 19 <i>60</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. Simon</i>		ADDRESS (Street, city or town, state) <i>Harford, Md.</i> DATE SIGNED <i>June 20</i>	
PHYSICIAN'S NAME (Type) <i>E. J. SIMON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/14/60</i>		22b. DATE THEREOF <i>6/14/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ms. Oliver</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Runington M. Hardey, Md.</i>		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>JUN 16 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hays</i>			

2362

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6966

06936

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>Two Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.F.D.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Baker</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Baker</u>		14. MOTHER'S MAIDEN NAME <u>Leah Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-18-3554</u>	
17. INFORMANT <u>W. H. Baker</u>		Address <u>Washington</u> <u>4420 Ottawa St. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Heart Failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>8 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 18, 1960</u> to <u>June 20, 1960</u> that (I) (we) last saw the deceased alive on <u>June 20, 1960</u> and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>June 21-1960</u>
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson, M.D.</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>	23b. DATE THEREOF <u>6-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>	23d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lea Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	25a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06937

6967

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>30min</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HARVE DE GRACE</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP</u>				1d. STREET ADDRESS <u>715 POLASKI Hwy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>BLUMBERG</u> Last <u>BLUMBERG</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WH.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 19, 1918</u>	
9. AGE (In years lost birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>HARRY BLUMBERG</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE ISREAL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>DR WOLBERT.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary occlusion -</u> DUE TO <u>Angina Pectoris.</u> (c) <u>Angina Pectoris.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1960</u> to <u>June 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1960</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Wolbert M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 7 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT M.D.</u>				22d. ADDRESS <u>HARVE DE GRACE Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/8/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MISHKIN ISRAEL CONG.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SOL LEVINSON & BROS INC. 6010 Reisterstown Rd.</u>				25a. REC'D BY REGISTRAR <u>JUN 10 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6958

CERTIFICATE OF DEATH

Reg. Dist. No.

66958

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 Edmund Street		d. STREET ADDRESS 103 Edmund Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDNA Middle WALTER Last BUDNICK		4. DATE OF DEATH Month June Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1878
9. AGE (In years lost birthday) yrs. 81		10. IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver Walter		14. MOTHER'S MAIDEN NAME Catherine Scarborough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. F. Hollis Budnick	
17. INFORMANT F. Hollis Budnick		Address 442 Wyn-Mar Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Terminal 6 mos. 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-19-60 to 6-26-60 , that I last saw the deceased alive on 6-26-60 , and that death occurred at 9:10 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aberdeen, Md. DATE SIGNED June 27 1960			
ACTUAL SIGNATURE Peter P. Rodman		M.D. Aberdeen, Md.	
PHYSICIAN'S NAME (Type) Peter P. Rodman		M.D. Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/29/60	22c. NAME OF CEMETERY OR CREMATORY St. Paul Luthern Cem.	22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tarring		24a. REC'D BY REGISTRAR June 30 '60	
ADDRESS Tarring Funeral Home Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

CERTIFICATE OF DEATH

1918

No. 111

Name of deceased
John J. Smith

Age

Sex

Date of death

Place of death

Cause of death

Disease

Time of death

Signature of physician

Signature of coroner

Signature of registrar

Signature of witness

Signature of undertaker

Signature of funeral home

Signature of cemetery

Signature of church

Signature of school

Signature of hospital

Signature of prison

Signature of other

Signature of family

Signature of friends

Signature of neighbors

Signature of community

Signature of society

Signature of association

Signature of organization

Signature of institution

Signature of government

Signature of state

Signature of federal

Signature of international

Signature of world

Signature of universe

Signature of nature

Signature of life

Signature of death

Signature of eternity

Signature of infinity

Signature of nothingness

Signature of everything

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6987

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shawsville				c. LENGTH OF STAY IN 1b 2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Herbert Last Cairnes				4. DATE OF DEATH Month June Day 18 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1885	
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director & Agent				10b. KIND OF BUSINESS OR INDUSTRY Mutual Insurance Co.		11. BIRTHPLACE (State or foreign country) Jarrettsville, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Andrew Cairnes				14. MOTHER'S MAIDEN NAME Cornealia Haile			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-3721		17. INFORMANT Mrs. Louise Cairnes Address Jarrettsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Disease years DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH immediate
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no accident or injury			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from Sept. 2 , 19 59 , to June 18 , 19 60 , that I last saw the deceased alive on June 6 , 19 60 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Houcks Mill Road DATE SIGNED June 18, 1960							
ACTUAL SIGNATURE James F. White, Jr.				PHYSICIAN'S NAME (Type) James F. White, Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/21/1960		22c. NAME OF CEMETERY OR CREMATORY Bethel	
22d. LOCATION (City, town, or county) (State) Madonna Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Rusty				ADDRESS Jarrettsville Md		24a. REC'D BY REGISTRAR JUN 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE CITY OF BALTIMORE		NAME OF DECEASED JAMES EARL RAY	
DATE OF BIRTH JANUARY 5, 1924		SEX MALE	
DATE OF DEATH APRIL 4, 1968		TIME OF DEATH 10:15 A.M.	
PLACE OF DEATH BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MEDICAL ATTENDANT DR. JAMES H. HARRIS	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF MEDICAL ATTENDANT DR. JAMES H. HARRIS	
SIGNATURE OF NEXT OF KIN JAMES EARL RAY		SIGNATURE OF WITNESSES JAMES EARL RAY	
SIGNATURE OF REGISTRAR JAMES EARL RAY		SIGNATURE OF CLERK JAMES EARL RAY	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06940
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN TB <u>Lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Thomas Run Road + Kelmia Road</u>		d. STREET ADDRESS <u>Thomas Run Road + Kelmia Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Anthony C. Clarke</u>		4. DATE OF DEATH <u>June 16 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 19, 1957</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Clarke Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Norma Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William L. Clarke Jr.</u>		Address <u>RD #1 Box 393 Bel Air, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause lost. DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell into farm pond</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-16-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm pond</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, MD</u> DATE SIGNED <u>6-16-60</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>JUNE 18, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fater</u> ADDRESS <u>W. Broadway + Williams St BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - JUNE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6282

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Baltimore, MD		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
June 15, 1965		10:30 AM		Home		Dr. Smith	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Printed Name of Medical Examiner		Printed Name of Coroner		Printed Name of Registrar		Printed Name of Witness	
John Doe		Jane Doe		John Doe		John Doe	
Title of Medical Examiner		Title of Coroner		Title of Registrar		Title of Witness	
Medical Examiner		Coroner		Registrar		Witness	
Signature of Deceased		Signature of Next of Kin		Signature of Burial Society		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]	
Printed Name of Deceased		Printed Name of Next of Kin		Printed Name of Burial Society		Printed Name of Cemetery	
John Doe		Jane Doe		John Doe		John Doe	
Address of Deceased		Address of Next of Kin		Address of Burial Society		Address of Cemetery	
123 Main St, Baltimore, MD		456 Main St, Baltimore, MD		789 Main St, Baltimore, MD		1011 Main St, Baltimore, MD	
Date of Burial		Time of Burial		Place of Burial		Cemetery	
June 17, 1965		11:00 AM		Home		St. John's Cemetery	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Printed Name of Medical Examiner		Printed Name of Coroner		Printed Name of Registrar		Printed Name of Witness	
John Doe		Jane Doe		John Doe		John Doe	
Title of Medical Examiner		Title of Coroner		Title of Registrar		Title of Witness	
Medical Examiner		Coroner		Registrar		Witness	

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case not within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6968
06941
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Steyford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Steyford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Havford Memorial Hospital</i>		d. STREET ADDRESS <i>31 Aberdeen, 354 Carter St</i>	
3. NAME OF DECEASED (Type or print) First <i>Jesse</i> Middle <i>B.</i> Last <i>Clifton</i>		4. DATE OF DEATH Month <i>June</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 16, 1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Machinist, U.S. Govt.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Samuel Clifton</i>		14. MOTHER'S MAIDEN NAME <i>Deceased Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>226-05-1633</i>	
17. INFORMANT <i>Wife</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Hemorrhage</i> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchial Asthma</i> DUE TO (c) <i>Cor Pulmonale</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>January 1958</i> to <i>June 24 1960</i> , that (I) (we) last saw the deceased alive on <i>June 24 1960</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Irvin Wachsmen</i>		22b. DATE SIGNED <i>6/24/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Irvin Wachsmen, M.D.</i>		22d. ADDRESS <i>407 S. Union Ave. Havre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/27/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Bakers Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>RD. Aberdeen, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i> ADDRESS <i>Funeral Home Aberdeen, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 28 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

John G. Tarring



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6969 CERTIFICATE OF DEATH

06942

06942

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 days 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>331 N. Union Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>RAE</u> Last <u>DELP</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1960</u>	
9. AGE (In years lost birthday) yrs. <u>22</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Olav Roy Delp</u>				14. MOTHER'S MAIDEN NAME <u>Alice Ernestine Ashby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Harford, Md.</u> <u>Olav R. Delp - 331 N. Union Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage (Subarachnoid)</u> <u>760.5</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Premature labor.</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1960</u> to <u>June 22, 1960</u> that (I) (we) last saw the deceased alive on <u>June 22, 1960</u> and that death occurred at <u>11:55 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William M. Leen</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/22/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William M. LEEN</u>				22d. ADDRESS <u>600 S. Union Ave. Haver de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6/23/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Huffman Family Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Princeton, R.I. - W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarrington</u>				25a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

2071262XV1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6970 CERTIFICATE OF DEATH

06943

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Main ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>E.</u> Last <u>Goodman</u>				4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1900</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Richard H. Goodman</u>				14. MOTHER'S MAIDEN NAME <u>Dora Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W. War</u>				16. SOCIAL SECURITY NO. <u>216-20-2276</u>		17. INFORMANT <u>Elmer Reedy</u> Address <u>Port Deposit Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>6-10</u> 19 <u>60</u> to <u>6-10</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>6-10</u> 19 <u>60</u> , and that death occurred on <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G.H. Richards Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.H. Richards Jr. M.D.</u>				22d. ADDRESS <u>Port Deposit, Md.</u>			
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-13-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Conowingo Baptist</u>		23d. LOCATION (City, town, or county) (State) <u>Conowingo, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lea Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

(M)

071

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98

(M)

6310

CERTIFICATE OF DEATH

DATE OF DEATH: 11-11-1900

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

CAUSE OF DEATH: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06944

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN 1b Harford Memorial Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Rural, d. STREET ADDRESS Box 622 (Van Bibber) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VIRGIE Middle M. Last HARRIS		4. DATE OF DEATH Month 6 Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Mask Assembler		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Melvin Tiller		14. MOTHER'S MAIDEN NAME Nora Mc Fadden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 213-16-9314	
17. INFORMANT Luther Harriid		Address Edgewood, R.D., Md.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of chest. DUE TO Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Auto-auto accident			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-auto accident	
20c. TIME OF INJURY Month, Day, Year 1:15 p.m. 6/1/ 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Edgewood		20f. (City or town) (County) (State) Edgewood Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 2, 1960			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or country) (State) Abingdon, Harford, Md.,	
23. FUNERAL DIRECTOR Howard K. Williams Jr.		24a. REC'D BY REGISTRAR DATE JUN 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

FOR SALE
MAY 1951

6831

WIND

Level of 6831

Level of 6831

Level of 6831

White

Gas Max Assembly

Mainly Tiller

12-16-51

Lucas Harris

Shawwood, N.D., No.

Gas Max Assembly

Level of 6831

6831

Level of 6831

12-16-51

Gas Max Assembly

Level of 6831

Shawwood, N.D., No.

Level of 6831

Level of 6831

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>				d. STREET ADDRESS <u>Front St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Blaine</u> Middle <u>G</u> Last <u>Hartenstine</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 25, 1881</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>19</u> Min. <u>60</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>17</u> Hours <u>19</u> Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad employee</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Peter Hartenstine</u>				14. MOTHER'S MAIDEN NAME <u>Sarah R. Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Malvin Hartenstine, Perryville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma, terminating</u> DUE TO (b) <u>Chronic cirrhosis of the liver</u> DUE TO (c) <u>Chronic bronchial asthma; Chronic cardio-vascular disease.</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>1 year 77</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchial asthma; Chronic cardio-vascular disease.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>June 30, 1959</u> to <u>June 17, 1960</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>June 17, 1960</u> , and that death occurred at <u>7:25 A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Willard P. Hudson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 17, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>				22d. ADDRESS <u>Forest Hill, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-19-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Principio Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Principio Furnace, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson & Son</u>				ADDRESS <u>Perryville, Md</u>		25a. REC'D BY REGISTRAR <u>June 20 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

6880

CENTRAL DE OBTAIN

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State

June 10, 1911

1911

Washington

State

Washington

State

Washington

State

Washington

State

Washington

State

Washington

State

June 10

William P. H. H. H.

Washington

State

June 10

Washington

State

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6972

06947

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Forrest Hill BEL Air Md</u>	
3. NAME OF DECEASED (Type or print) <u>Carl</u> First <u>Henry</u> Middle <u>Henderson</u> Last		4. DATE OF DEATH <u>6</u> Month <u>10</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charlie Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Alice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs Mack Dixon</u> Address <u>Prospect Mills Rd. Bel Air</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>asthma</u> DUE TO (c) <u>emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> 19 <u>60</u> to <u>June 10</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>June 10</u> 19 <u>60</u> , and that death occurred at <u>6:25 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>E. J. Simon</u>		22b. DATE SIGNED <u>6-10-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>		22d. ADDRESS <u>Hartford Grace, Md.</u>	
23a. BURIAL, CREMATION, (REMOVAL) (Specify)		23b. DATE THEREOF <u>6/11/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>REEDY</u>		23d. LOCATION (City, town, or county) (State) <u>RUGBY Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Emmylou R. Hand</u>		25a. REC'D BY REGISTRAR <u>Jun 14 '60</u>	
ADDRESS <u>Richmond Va. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

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CHIEF

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6961

Item 7 Film 6266 6-20-60 et

Reg. Dist. No.

06948

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>11</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18</u> 3V01.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Emford Ave</u>		d. STREET ADDRESS <u>2726 Tindley Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mark Spangler Hudson</u>		4. DATE OF DEATH Month Day Year <u>June 11 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-10</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Greenwell W. Va</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilbur H Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Marla May Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Reba Ann Hudson</u>		Address <u>2726 Tindley Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-objed type</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 6-11 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Emford Ave</u>		20f. (City or town) <u>Belt Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Belt Air, Md</u> DATE SIGNED <u>6-11-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sons of Sun</u>	22d. LOCATION (City, town, or county) (State) <u>Belt Air W. Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard S. Ruck, Inc</u>		ADDRESS <u>3305 Hackett Rd</u>	
24a. REC'D BY REGISTRAR <u>JUN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66949

6973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>AMY ADELAIDE DECKMAN JAMISON</u>		4. DATE OF DEATH Month <u>6</u> / Day <u>7</u> / Year <u>19 60</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WAKEMAN JOURDAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY M. MITCHELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. CONNIE BAKER</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u> </u> <u> </u> <u>19</u> p. m. <u> </u> <u> </u> <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5</u> , 19 <u>58</u> , to <u>6/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/5</u> , 19 <u>60</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>6/7/60</u>	
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		DATE SIGNED <u>6/7/60</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr. M.D.</u>		DATE SIGNED <u>6/7/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/10/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK RUN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>DARLINGTON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carmon E. McHaul</u>		ADDRESS <u>RISING SUN, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. H. H.</u>	

CERTIFICATE OF DEATH

1923

Reg. Dist. No.

Place of Birth

Married

State of Birth

Place of Death

Married

State of Birth

Place of Death

Married

State of Birth

Place of Death

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06950

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18</u> 3V01.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fenford Ave</u>		d. STREET ADDRESS <u>3910 SCLAIR RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cecil R Jones</u> First Middle Last		4. DATE OF DEATH <u>June 11</u> 19 <u>60</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30 1910</u> 50 yrs.
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Raleigh, W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alphonse Jones</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Woods</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alice Jean Jones</u> Address <u>3910 SCLAIR RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Auto accident auto - subject type</u>	
20c. TIME OF INJURY Hour <u>730</u> o. m. <u>6-11</u> 19 <u>60</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Fenford Ave</u>	20f. (City or town) <u>Belt Air</u> (County) <u>Harford</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Belt Air Md</u> DATE SIGNED <u>6-11-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prosperity Cem</u>	22d. LOCATION (City, town, or county) <u>Beckley W. Va</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ryck, Inc</u> ADDRESS <u>305 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>JUN 15 60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Forward</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the instructions on the reverse side of this certificate. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1965

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. RACE</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. SOCIAL SECURITY NUMBER</p> <p>12. HOME ADDRESS</p> <p>13. PHONE NUMBER</p> <p>14. MOTHER'S MAIDEN NAME</p> <p>15. FATHER'S NAME</p> <p>16. DATE OF DEATH</p> <p>17. TIME OF DEATH</p> <p>18. PLACE OF DEATH</p> <p>19. CAUSE OF DEATH</p> <p>20. MANNER OF DEATH</p> <p>21. SIGNATURE OF MEDICAL EXAMINER</p> <p>22. SIGNATURE OF WITNESS</p> <p>23. SIGNATURE OF CORONER</p> <p>24. SIGNATURE OF JURY</p> <p>25. SIGNATURE OF JUDGE</p> <p>26. SIGNATURE OF CLERK</p> <p>27. SIGNATURE OF SHERIFF</p> <p>28. SIGNATURE OF DEPUTY SHERIFF</p> <p>29. SIGNATURE OF CONSTABLE</p> <p>30. SIGNATURE OF DEPUTY CONSTABLE</p> <p>31. SIGNATURE OF JURY MEMBER</p> <p>32. SIGNATURE OF JURY MEMBER</p> <p>33. SIGNATURE OF JURY MEMBER</p> <p>34. SIGNATURE OF JURY MEMBER</p> <p>35. SIGNATURE OF JURY MEMBER</p> <p>36. SIGNATURE OF JURY MEMBER</p> <p>37. SIGNATURE OF JURY MEMBER</p> <p>38. SIGNATURE OF JURY MEMBER</p> <p>39. SIGNATURE OF JURY MEMBER</p> <p>40. SIGNATURE OF JURY MEMBER</p> <p>41. SIGNATURE OF JURY MEMBER</p> <p>42. SIGNATURE OF JURY MEMBER</p> <p>43. SIGNATURE OF JURY MEMBER</p> <p>44. SIGNATURE OF JURY MEMBER</p> <p>45. SIGNATURE OF JURY MEMBER</p> <p>46. SIGNATURE OF JURY MEMBER</p> <p>47. SIGNATURE OF JURY MEMBER</p> <p>48. SIGNATURE OF JURY MEMBER</p> <p>49. SIGNATURE OF JURY MEMBER</p> <p>50. SIGNATURE OF JURY MEMBER</p> <p>51. SIGNATURE OF JURY MEMBER</p> <p>52. SIGNATURE OF JURY MEMBER</p> <p>53. SIGNATURE OF JURY MEMBER</p> <p>54. SIGNATURE OF JURY MEMBER</p> <p>55. SIGNATURE OF JURY MEMBER</p> <p>56. SIGNATURE OF JURY MEMBER</p> <p>57. SIGNATURE OF JURY MEMBER</p> <p>58. SIGNATURE OF JURY MEMBER</p> <p>59. SIGNATURE OF JURY MEMBER</p> <p>60. SIGNATURE OF JURY MEMBER</p> <p>61. SIGNATURE OF JURY MEMBER</p> <p>62. SIGNATURE OF JURY MEMBER</p> <p>63. SIGNATURE OF JURY MEMBER</p> <p>64. SIGNATURE OF JURY MEMBER</p> <p>65. SIGNATURE OF JURY MEMBER</p> <p>66. SIGNATURE OF JURY MEMBER</p> <p>67. SIGNATURE OF JURY MEMBER</p> <p>68. SIGNATURE OF JURY MEMBER</p> <p>69. SIGNATURE OF JURY MEMBER</p> <p>70. SIGNATURE OF JURY MEMBER</p> <p>71. SIGNATURE OF JURY MEMBER</p> <p>72. SIGNATURE OF JURY MEMBER</p> <p>73. SIGNATURE OF JURY MEMBER</p> <p>74. SIGNATURE OF JURY MEMBER</p> <p>75. SIGNATURE OF JURY MEMBER</p> <p>76. SIGNATURE OF JURY MEMBER</p> <p>77. SIGNATURE OF JURY MEMBER</p> <p>78. SIGNATURE OF JURY MEMBER</p> <p>79. SIGNATURE OF JURY MEMBER</p> <p>80. SIGNATURE OF JURY MEMBER</p> <p>81. SIGNATURE OF JURY MEMBER</p> <p>82. SIGNATURE OF JURY MEMBER</p> <p>83. SIGNATURE OF JURY MEMBER</p> <p>84. SIGNATURE OF JURY MEMBER</p> <p>85. SIGNATURE OF JURY MEMBER</p> <p>86. SIGNATURE OF JURY MEMBER</p> <p>87. SIGNATURE OF JURY MEMBER</p> <p>88. SIGNATURE OF JURY MEMBER</p> <p>89. SIGNATURE OF JURY MEMBER</p> <p>90. SIGNATURE OF JURY MEMBER</p> <p>91. SIGNATURE OF JURY MEMBER</p> <p>92. SIGNATURE OF JURY MEMBER</p> <p>93. SIGNATURE OF JURY MEMBER</p> <p>94. SIGNATURE OF JURY MEMBER</p> <p>95. SIGNATURE OF JURY MEMBER</p> <p>96. SIGNATURE OF JURY MEMBER</p> <p>97. SIGNATURE OF JURY MEMBER</p> <p>98. SIGNATURE OF JURY MEMBER</p> <p>99. SIGNATURE OF JURY MEMBER</p> <p>100. SIGNATURE OF JURY MEMBER</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6974

CERTIFICATE OF DEATH

06952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>		24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>724 Erie</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine Langnis</u> First Middle Last				4. DATE OF DEATH <u>6/11/60</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/19/1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Coniti</u>				14. MOTHER'S MAIDEN NAME <u>Ida Polletti</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>724 Erie St. Harford Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Chronic Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>57 minutes</u> <u>1 hour</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>60</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 North Union Ave Harford Chase, Md.</u> DATE SIGNED <u>6/12/60</u>							
ACTUAL SIGNATURE <u>Frank Wolbert MD</u>				PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD Harford Chase, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Erie</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Chase, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin R. R. Harford Chase, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

6374 (1) CERTIFICATE OF DEATH

MIN
FRED
MAY 1941

NAME OF DECEASED		DATE OF DEATH	
FRED M. MAY		MAY 1941	
AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		OFFICIAL USE	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06953

6959

Items 7, 12 File G265 6-17-60 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penna. R.R. Tracks		d. STREET ADDRESS R.D. #3	
3. NAME OF DECEASED (Type or print) First Wasil Middle Meluk Last Meluk		4. DATE OF DEATH Month June Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH Apr. 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Industry	11. BIRTHPLACE (State or foreign country) Russia
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		17. INFORMANT Chas. B. Osborn Jr.	
16. SOCIAL SECURITY NO. 215-05-8204		Address R.D. 3 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Body dismemberment DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 802x DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walked across R.R. tracks & Train struck him.	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 10:00 6-9 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Penna R.R Tracks		20f. (City or town) (County) (State) Aberdeen Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bertin, Md	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6-9-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/11/60	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		24a. REC'D BY REGISTRAR DATE JUN 14 '60	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR STATE
HEALTH DEPT



0322

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JACOBSON, JACOB		AGE 45	SEX M	RACE W	DATE OF BIRTH JAN 15 1880	PLACE OF BIRTH RUSSIA
RESIDENCE 123 MAIN ST, BOSTON, MASS		OCCUPATION LABORER				
DATE OF DEATH JAN 20 1920		PLACE OF DEATH HOME				
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL				
SIGNATURE OF EXAMINER J. J. JACOBSON		DATE JAN 20 1920				
SIGNATURE OF WITNESSES J. J. JACOBSON		DATE JAN 20 1920				
SIGNATURE OF CLERK J. J. JACOBSON		DATE JAN 20 1920				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06954

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

6989

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>		c. LENGTH OF STAY IN 1b <u>9 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 750A ALEXIS DR., RD#2 JOPPA, Md</u>				d. STREET ADDRESS <u>Box 750A ALEXIS DR. RD#2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROY LOCKWOOD MILLER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>19 60</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24 1919</u>		9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLWRIGHT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOTIVE</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LUTHER CARL MILLER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET MARIE GRIMES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>168-09-5350</u>		17. INFORMANT <u>TOM MILLER 4 QUINCE LANE BALTIMORE 20, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN ABOUT 3 WKS</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lloyd</u>		22d. LOCATION (City, town, or county) (State) <u>Ebensburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LASSA H N FUNERAL</u> <u>HOME, BALTIMORE, MD</u>				24a. REC'D BY REGISTRAR <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6975

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>11 Monroe St.</u>			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>L.</u> Middle <u>Moore</u> Last <u>R</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1931</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13. FATHER'S NAME <u>Jack Cottman</u>				14. MOTHER'S MAIDEN NAME <u>Martha Woodley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>213-26-6414</u>			
17. INFORMANT <u>Mrs. Martha J. Cottman, Havre-de-Grace, Md.</u>				Address <u>3 Maple St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute yellow atrophy liver</u> 580x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/28/1960</u> to <u>6/2/1960</u> that I last saw the deceased alive on <u>6/2/1960</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Havre de Grace, Md.</u>				DATE SIGNED <u>6/2/60</u>			
ACTUAL SIGNATURE <u>Irvin L. Wachsman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Irvin L. Wachsman, M.D.</u>				<u>Havre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Little Mount Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Sussex County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u> ADDRESS <u>Havre de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>June 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kiser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



March 22, 1901

at 11

3132-PAID THE DEATH OF

James E. Kunkel, Householder, died at the St. Vincent Hospital, New York County, New York, on March 22, 1901, at the age of 68 years.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20 Fl 265 6-21-60 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
06956											
6990 Phone Call - Med. Ex. Office - 665-4760-200											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY HARFORD						a. STATE Pennsylvania b. COUNTY Chester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Belair West Chester					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS R.F.D. #4					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Brought home on the beach at)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last JOHN S. MORRIS						Month Day Year June 16 19 60					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept 14, 1906		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Eng.		10b. KIND OF BUSINESS OR INDUSTRY Lukens Steel Co. Pa. Offd., N.C.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Joseph A. Morris						14. MOTHER'S MAIDEN NAME Lizzie Martin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT Address Jessie Bird Day Morris											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning											
850X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell overboard from a runabout boat											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/11/60 8:00 PM											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East River											
20f. (City or town) Harford (County) (State) Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
DATE SIGNED June 16, 1960											
ACTUAL SIGNATURE Wm. J. Tickner											
EXAMINER'S NAME (Type) Wm. J. Tickner											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal											
22b. DATE THEREOF 6/17/60											
22c. NAME OF CEMETERY OR CREMATORY Marshalltown Methodist											
22d. LOCATION (City, town, or country) Chester Co. Pa.											
23. FUNERAL DIRECTOR Wm. J. Tickner & Sons - Belts. Md.											
24a. REC'D BY REGISTRAR DATE JUN 20 '60											
24b. REGISTRAR'S SIGNATURE											

RECEIVED
JUL 10 1960

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(M)

(1)

to mine

W. J. [Signature]

20/1/60

10/1/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6991

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06957

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		c. LENGTH OF STAY in 1b <u>6 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Friends Bar</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Goldie E. Nichols</u> First Middle Last		4. DATE OF DEATH <u>June 14</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Herman W. Neeley</u>	
14. MOTHER'S MAIDEN NAME <u>Tressie K. Marion</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>235-28-6004</u>		17. INFORMANT <u>L.S. Neeley,</u> Address <u>Elkview W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>25W chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>97762</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self with pistol</u>	
20c. TIME OF INJURY Month, Day, Year <u>12/15</u> Hour <u>6-14</u> p. m. <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Friends Bar</u>		20f. (City or town) <u>Abingdon</u> (County) <u>Ha</u> (State) <u>md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6-14-60 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Boatman</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>June 15, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hafer Funeral Home</u>	22d. LOCATION (City, town, or county) <u>Elkview, Kanawha</u> (State) <u>W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward L. Brown</u>		24a. REC'D BY REGISTRAR <u>June 17 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

06958
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stuffed Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Darlington</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah A Parden</u>		4. DATE OF DEATH <u>June 9 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17 1876</u>
9. AGE (In years last birthday) <u>83 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 74 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Allegheny Co. Md. U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henderson Chees</u>		14. MOTHER'S MAIDEN NAME <u>Millie Hagans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MD</u>	
17. INFORMANT <u>Amory Parden</u>		Address <u>Darlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior scientific C V disease</u> 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>60</u> , to <u>6-9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-6</u> , 19 <u>60</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Del Air, Md</u> DATE SIGNED <u>6-11-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 12 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cm.</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u>		ADDRESS <u>Darlington Md</u>	
24a. REC'D BY REGISTRAR <u>JUN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Fennell</u>	

may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>None de Ruud</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 None de Ruud</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hospital</u>		d. STREET ADDRESS <u>801 So. Wash. St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>James</u> Last <u>Reasin</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/1891</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>17</u> Min.	11. IF UNDER 24 HRS. Months <u>6</u> Days <u>17</u> Hours <u>17</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GRACE FOREMAN USGANT RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAURE de GRACE Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED REASIN</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA TOWNSLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>MRS HARRY REASIN</u>		Address <u>801 S Washington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> 19 <u>60</u> to <u>6/17</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>6/17</u> 19 <u>60</u> and that death occurred at <u>7:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas H. Wallsman</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>6/20/1960</u>	<u>ANGEL Hill</u>	<u>HAURE de GRACE Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Connington & Son</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6994

CERTIFICATE OF DEATH

Reg. Dist. No.

06960

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 29	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 Pusey Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MALISSA Middle M. Last RICHARDSON		4. DATE OF DEATH Month June Day 27 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1898
9. AGE (In years last birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse E. McMillan		14. MOTHER'S MAIDEN NAME Fannie Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-4036	
17. INFORMANT Harry L. Richardson, Havre de Grace, Md.		Address 100 Pusey St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Normal cardiac thrombosis DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) bronchial asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 27 , 19 60 , to June 27 , 19 60 , that I last saw the deceased alive on June 27 , 19 60 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irvin Wachsmann		ADDRESS (Street, city or town, state) DATE SIGNED 407 S. Union Ave. 6/28/60	
PHYSICIAN'S NAME (Type) Irvin Wachsmann, M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/2/60	22c. NAME OF CEMETERY OR CREMATORY Center Cemetery	22d. LOCATION (City, town, or county) (State) Nathans Creek, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		24a. REC'D BY REGISTRAR DATE JUN 30 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
John A. Smith		Male		White		1900 Jan 15		1950 Jan 15	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Physician	
New York City		New York City		Heart Disease		Natural		Dr. J. B. Jones	
11. Signature of Physician		12. Signature of Registrar		13. Signature of Informant		14. Signature of Deceased		15. Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. Date of Report		17. Name of Hospital		18. Name of Doctor		19. Name of Nurse		20. Name of Attending Physician	
1950 Jan 15		St. Mary's Hospital		Dr. J. B. Jones		Miss M. A. Smith		Dr. J. B. Jones	
21. Name of Informant		22. Name of Informant		23. Name of Informant		24. Name of Informant		25. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
26. Name of Informant		27. Name of Informant		28. Name of Informant		29. Name of Informant		30. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
31. Name of Informant		32. Name of Informant		33. Name of Informant		34. Name of Informant		35. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
36. Name of Informant		37. Name of Informant		38. Name of Informant		39. Name of Informant		40. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
41. Name of Informant		42. Name of Informant		43. Name of Informant		44. Name of Informant		45. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
46. Name of Informant		47. Name of Informant		48. Name of Informant		49. Name of Informant		50. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
51. Name of Informant		52. Name of Informant		53. Name of Informant		54. Name of Informant		55. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
56. Name of Informant		57. Name of Informant		58. Name of Informant		59. Name of Informant		60. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
61. Name of Informant		62. Name of Informant		63. Name of Informant		64. Name of Informant		65. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
66. Name of Informant		67. Name of Informant		68. Name of Informant		69. Name of Informant		70. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
71. Name of Informant		72. Name of Informant		73. Name of Informant		74. Name of Informant		75. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
76. Name of Informant		77. Name of Informant		78. Name of Informant		79. Name of Informant		80. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
81. Name of Informant		82. Name of Informant		83. Name of Informant		84. Name of Informant		85. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
86. Name of Informant		87. Name of Informant		88. Name of Informant		89. Name of Informant		90. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
91. Name of Informant		92. Name of Informant		93. Name of Informant		94. Name of Informant		95. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	
96. Name of Informant		97. Name of Informant		98. Name of Informant		99. Name of Informant		100. Name of Informant	
John A. Smith		John A. Smith		John A. Smith		John A. Smith		John A. Smith	

CERTIFICATE OF DEATH

06961

Reg. Dist. No.

6995

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) JARRETTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>12 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD #1 Rocks, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA ELLEN RICHARDSON</u>		4. DATE OF DEATH Month Day Year <u>JUNE 1 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 17, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11c. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN ABSHER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET WAGONER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-12-2674</u>	
17. INFORMANT Address <u>Rocks, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, LOBAR</u> 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LEFT HEMIPLEGIA, PARTIAL</u> DUE TO (c) <u>2 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 23, 1960</u> , to <u>MAY 31, 1960</u> , that I last saw the deceased alive on <u>MAY 31, 1960</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		ADDRESS (Street, city or town, state) <u>307 HICKORY</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN</u>		DATE SIGNED <u>JUNE 4 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u>		ADDRESS <u>Jarrettsville Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kutz</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6092



Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is partially filled with handwritten text and includes a large diagonal line across the bottom half.

Handwritten text visible on the form includes:

- NAME: [illegible]
- DATE: 10-17-1942
- TIME: 10:00 AM
- CAUSE OF DEATH: [illegible]
- PLACE OF DEATH: [illegible]
- AGE: 24
- SEX: F
- RACE: W
- RELIGION: [illegible]
- EDUCATION: [illegible]
- OCCUPATION: [illegible]
- DATE OF BIRTH: [illegible]
- PLACE OF BIRTH: [illegible]
- DATE OF DEATH: 10-17-1942
- TIME OF DEATH: 10:00 AM
- CAUSE OF DEATH: [illegible]
- PLACE OF DEATH: [illegible]
- AGE: 24
- SEX: F
- RACE: W
- RELIGION: [illegible]
- EDUCATION: [illegible]
- OCCUPATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6976
CERTIFICATE OF DEATH
06962

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD (Cecil)</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>07X-2</u>	
3. NAME OF DECEASED (Type or print) <u>BABY Boy</u>		4. DATE OF DEATH <u>June 5</u> 1960	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5, 1960</u>	
9. AGE (In years last birthday) yrs. <u>—</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. FATHER'S NAME <u>William Rierson</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Delp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William Rierson</u>		Address <u>Rising Sun, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Orlinda S. Marbella</u>		22b. DATE SIGNED <u>6/6/1960</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Nottingham Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Calora Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Mc-Mullen</u>		25a. REC'D BY REGISTRAR <u>June 9 '60</u>	
Address <u>Rising Sun, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Orlinda S. Marbella</u>	

3071181XV5

CERTIFICATE OF DEATH

6328



CHIEF OF DIVISION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6977

CERTIFICATE OF DEATH

06963
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace				c. LENGTH OF STAY IN 1b X Aberdeen (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital				d. STREET ADDRESS R.D. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle C Last SCHANTZ				4. DATE OF DEATH Month June Day 6 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9, 1899	
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John George Schantz				14. MOTHER'S MAIDEN NAME May F. Reauter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-03-2962		17. INFORMANT Address R.D. #2 Helen M. Schantz, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month June Day 19 Year 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bel Air, Md.	
20f. (City or town) Bel Air, Md.				20g. (County) Harford			
20h. (State) Md.							
21. I certify that I attended the deceased from 6 June 1960 , to 6 June 1960 , that I last saw the deceased alive on 6 June 1960 , and that death occurred at 12:01 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bel Air, Md. DATE SIGNED Charles Richardson Jr.							
ACTUAL SIGNATURE Charles Richardson Jr.				M.D. Charles Richardson Jr.			
PHYSICIAN'S NAME (Type) Charles Richardson Jr. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. 2, Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				24a. REC'D BY REGISTRAR DATE JUN 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

6977

<p>NAME OF DECEASED [Illegible]</p>		<p>AGE [Illegible]</p>	
<p>SEX [Illegible]</p>		<p>DATE OF BIRTH [Illegible]</p>	
<p>PLACE OF BIRTH [Illegible]</p>		<p>DATE OF DEATH [Illegible]</p>	
<p>CAUSE OF DEATH [Illegible]</p>		<p>PLACE OF DEATH [Illegible]</p>	
<p>DATE OF INTERMENT [Illegible]</p>		<p>PLACE OF INTERMENT [Illegible]</p>	
<p>SIGNATURE OF REGISTRAR [Illegible]</p>		<p>DATE [Illegible]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6978

CERTIFICATE OF DEATH

Reg. Dist. No.

06964

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE-DE-GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		d. STREET ADDRESS 07X-2	
3. NAME OF DECEASED (Type or print) First PAULINE Middle SHMEL Last SHMEL		4. DATE OF DEATH Month JUNE Day 30 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 18, 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL DEMICK		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MICHAEL SHMEL		Address RISING SUN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420-00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10 , 19 60 , to 6/30 , 19 60 , that I last saw the deceased alive on 6/30 , 19 60 , and that death occurred at 7P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor		DATE SIGNED 7/1/60	
PHYSICIAN'S NAME (Type) Neil Taylor Jr		ADDRESS (Street, city or town, state) Rising Sun, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		22d. LOCATION (City, town, or county) (State) HARTFORD CONN.	
23. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMillen		24a. REC'D BY REGISTRAR JUL 5 '60	
ADDRESS Rising Sun Md		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. PLACE OF BIRTH <i>Maryland</i>		5. DATE OF BIRTH <i>Jan 15 1880</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. TIME OF DEATH <i>10:00 AM</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. DATE OF DEATH <i>Jan 20 1945</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. PLACE OF DEATH <i>Home</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
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49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
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85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	

1. NAME OF DECEASED
2. SEX
3. AGE
4. PLACE OF BIRTH
5. DATE OF BIRTH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. TIME OF DEATH
10. SIGNATURE OF PHYSICIAN
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13. DATE OF DEATH
14. TIME OF DEATH
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101. SIGNATURE OF WITNESS
102. SIGNATURE OF PHYSICIAN

6979

CERTIFICATE OF DEATH

Reg. Dist. No. 06965

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 St Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>653 St. Clair St.</u>		1 d. STREET ADDRESS <u>1653 St. Clair St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-1909</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Culture</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George H. Hoke</u>		14. MOTHER'S MAIDEN NAME <u>Mazie Kell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-32-4130</u>	
17. INFORMANT <u>Mrs. Margaret Hoke, Harre de Grace, Md.</u>		Address <u>511 Pink Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last: (b) <u> </u> DUE TO (c) <u>Hypertensive-Arteriosclerotic Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Day of Death</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>June 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 14</u> , 19 <u>60</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>George T. Stansbury, 569 Revolution Street, Harre de Grace, Md.</u>		DATE SIGNED <u>6/15/60</u>	
ACTUAL SIGNATURE <u>George T. Stansbury</u>		PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-18-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullock, Harre de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>June 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6980

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>J.</u> Last <u>SMITHSON</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/00</u>
9. AGE (In years last birthday) <u>60 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SLATE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES SMITHSON</u>	
14. MOTHER'S MAIDEN NAME <u>OLIVIA SMITHSON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>184-05-1577</u>		INFORMANT <u>E. R. JONES</u> Address <u>(SAME AS ABOVE)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pertussis etiology unknown.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Debts unpaid, Cardiac degeneration</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5/31</u> , 19 <u>60</u> , to <u>6/5</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>6/5</u> , 19 <u>60</u> , and that death occurred at <u>12:45</u> M. from the causes and on the date stated above. <u>W. K. Greenole</u> ADDRESS (Street, city or town, state) <u>HARFORD MEM. HOSP.</u> DATE SIGNED <u>6/5/60</u>			
ACTUAL SIGNATURE <u>W. K. GREENOLE</u>		PHYSICIAN'S NAME (Type) <u>J. KHALATBACH</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>DELTA, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Nabins</u>		24a. REC'D BY REGISTRAR <u>JUN 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

06967

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. STREET ADDRESS <u>1516 N. Adams</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WARNER B. TAYLOR</u>				4. DATE OF DEATH Month Day Year <u>JUNE 27 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25-1873</u>		9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE WARNER B. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>MARY Ann Hague</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mell A. Taylor</u> Address <u>516 N. Adams Harford de Grace Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, Metastatic</u> 177X DUE TO (b) <u>Ca. of prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>June 19th 1960</u> to <u>June 27th 1960</u> that (I) (we) last saw the deceased alive on <u>June 27 1960</u> and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/27/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22d. ADDRESS <u>211 N. Union Ave. Harford de Grace Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elkton</u>		23d. LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Conroy</u>				ADDRESS <u>Harford de Grace Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 1 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

1881

CENTRAL CALIF. CO.

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "California" and "Central" are faintly visible.]

(1)

(1)

063

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>950 Mississippi Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>Walter</u> Last <u>Walter</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 14, 1920</u> 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENTERTAINMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY WARSHAWSKY</u>		14. MOTHER'S MAIDEN NAME <u>ROSE LOSIKOFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>133-079-97A</u>	
17. INFORMANT <u>SIDNEY RAPKE</u> Address <u>BETHESDA Md. 6304 E. HALBERT RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury Chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>A into accident auto auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>1201 p.m. 6-10-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. B. A. M.D.</u> DATE SIGNED <u>6-10-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 12, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danganer & Son</u> ADDRESS <u>3501-14 N. Wm</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>William B. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

6983

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06969

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAURE DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>108 WILSON ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL</u> <u>EMANUEL</u> <u>WEAVER</u>		4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>27</u> <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/03</u>
9. AGE (In years last birthday) <u>56 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISABLED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel M. Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Albina Regel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. 2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>BETTY J. WEAVER</u>		Address <u>SAME.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>58</u> , to <u>June 27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> , 19 <u>60</u> , and that death occurred at <u>2:20</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Irvin N. Wachsman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>IRVIN N. WACHSMAN</u>		22d. ADDRESS <u>6/27/60</u>	
23a. URIAL CREMATION, RURAL (Specify) <u>6/30/60</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Hoffman</u>		23d. LOCATION (City, town, county) (State) <u>New Hamburg Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel H. Hahn, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 28 '60</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

10/10



CENTRAL AFRICA DEPT

6083



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06970**

6984

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Brook</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POA Harford Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Brook</u>			
f. STREET ADDRESS <u>RD 2</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>E</u> Last <u>Wilkinson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1898</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liberty Brown</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Walter Wilkinson</u>				14. MOTHER'S MAIDEN NAME <u>Lela Carr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-01-6545</u>		17. INFORMANT <u>Mrs. Ira Wilkinson</u> Address <u>off Harrode Brook Rural</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Loraly C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerold C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 25, 1960 Fishman Chapel</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Harford Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				ADDRESS <u>Washington Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6985

CERTIFICATE OF DEATH

06971

1. PLACE OF DEATH a. COUNTY <i>Stearns</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Georgetown</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stearns</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Georgetown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Stearns Memorial Hospital</i>		d. STREET ADDRESS <i>49 So. Main St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Pauline</i> Middle <i>Will</i> Last <i>Will</i>		4. DATE OF DEATH Month <i>June</i> Day <i>22</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-1888</i>
9. AGE (in years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Brauer</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-34-0563</i>	
17. INFORMANT <i>Muriel Jackson - Perryville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cerebral Vascular Disease</i> DUE TO <i>10 yrs.</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 19 46</i> to <i>June 22 1960</i> , that (I) (we) last saw the deceased alive on <i>June 22 1960</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>G.H. Richards Jr.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>G.H. Richards Jr. M.D.</i>		22d. ADDRESS <i>Port Deposit, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-24-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>West Nottingham Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Coloma, Md. Rural</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. A. Patterson & Son</i>		25a. REC'D BY REGISTRAR <i>June 24 '60</i>	
ADDRESS <i>Perryville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

6082

CERTIFICATE OF DEATH

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U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20001

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06972

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air,</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Isabelle</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1868</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harvey Pennington</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Arthur C Ashleys</u>		Address <u>Bel Air</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio-vascular disease</u> DUE TO <u>?</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>June</u> , 19 <u>60</u> that I last saw the deceased alive on <u>June 9</u> , 19 <u>60</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>—</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

Reg. Dist. No. **06973****6996**

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Lida Middle M. Last Willis				4. DATE OF DEATH Month June , Day 27 , Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1882	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Churchville, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME William A. Bodt				14. MOTHER'S MAIDEN NAME Annie Preston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Levering O. Willis Abingdon Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.1 IMMEDIATE CAUSE (a) Gangrene left lower leg DUE TO years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterial sclerosis - hemiplegia DUE TO 2 months (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 15, 1960 , to June 27, 1960 , that I last saw the deceased alive on June 27, 1960 , and that death occurred at 7:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Led O. Hodous M.D.				ADDRESS (Street, city or town, state) Edgewood Maryland. DATE SIGNED			
PHYSICIAN'S NAME (Type) Fred O. Hodous				Edgewood Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Smith's Chapel		22d. LOCATION (City, town, or county) (State) Churchville Harford Md.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown				ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR DATE JUL 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6986

CERTIFICATE OF DEATH

06974

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>Wilmington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shore de Grace</i>		c. LENGTH OF STAY IN lb <i>DOA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>300 E. 25th St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Gabella</i> Middle <i>Hinn</i> Last <i>Hinn</i>		4. DATE OF DEATH Month <i>June</i> Day <i>25</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 12, 1877</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bayview, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Ray</i>		14. MOTHER'S MAIDEN NAME <i>Hester Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Robert C. Hinn, Jr.</i>		Address <i>Rt. # 40 Shore de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Myocardial</i> <i>592X</i> DUE TO <i>Cardiac Vascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Degenerative</i> (c) <i>Reflex</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-6</i> 19 <i>60</i> to <i>6-27</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>June 24</i> 19 <i>60</i> , and that death occurred at <i>12:30</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Elmer E. Bullock</i>		22b. DATE SIGNED <i>6/26/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Elmer E. Bullock</i>		22d. ADDRESS <i>Shore de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 28, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Baptist Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>North East, Cecil Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock</i>		25a. REC'D BY REGISTRAR <i>Arthur L. Kraus</i>	
ADDRESS <i>Shore de Grace, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	
DATE <i>JUN 29 '60</i>			

John

MALE

White

Single

Married

Widowed

Divorced

Never

Married

Widowed

Divorced

Never

Married

Widowed

Divorced

Never

Married

Widowed

Divorced

Never

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06975

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 7-103. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> c. LENGTH OF STAY IN 1b <u>34 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RD</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> d. STREET ADDRESS <u>RD</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Yingling Wright</u>				4. DATE OF DEATH Month Day Year <u>June 28 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-22-1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				13b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>			
14. BIRTHPLACE (State or foreign country) <u>HARFORD CO., MD</u>				15. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
16. FATHER'S NAME <u>WILLIAM A. WRIGHT</u>				17. MOTHER'S MAIDEN NAME <u>R. VIRGINIA BULL</u>			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				19. SOCIAL SECURITY NO. <u>219-36-0459</u>			
20. INFORMANT <u>W. K. Wright</u>				21. ADDRESS <u>Pylesville RD, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
23c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		23d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		23e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>				CHIEF MEDICAL EXAMINER <u>Beltz, W</u>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>				DEPUTY MEDICAL EXAMINER <u>A</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL METH.</u>	
22d. LOCATION (City, town, or country) <u>NORRISVILLE, HARFORD CO., MD.</u>				22e. (State)			
23. FUNERAL DIRECTOR <u>Heanith W. Shum</u>				23a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
23b. ADDRESS <u>Stewarttown Penna.</u>				23c. DATE <u>JUN 30 '60</u>			

THE STATE
HEALTH DEPARTMENT
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

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